Reproductive Health Knowledge and Practices in Northern Nigeria:
Challenging Misconceptions

The Reproductive Health/Family Planning Service Delivery Project
in Northern Nigeria

With Funding From the David and Lucile Packard Foundation
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### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CBD</td>
<td>Community Based Distributor</td>
</tr>
<tr>
<td>FCT</td>
<td>Federal Capital Territory</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDI</td>
<td>In-Depth Interview</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>MBD</td>
<td>Market-Based Distributor</td>
</tr>
<tr>
<td>MM</td>
<td>Male Motivator</td>
</tr>
<tr>
<td>MRA</td>
<td>Men of Reproductive Age</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
</tr>
<tr>
<td>PHE</td>
<td>Peer Health Educators</td>
</tr>
<tr>
<td>PMV</td>
<td>Patent Medicine Vendors</td>
</tr>
<tr>
<td>PPFN</td>
<td>Planned Parenthood Federation of Nigeria</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WRA</td>
<td>Women of Reproductive Age</td>
</tr>
<tr>
<td>YFC</td>
<td>Youth-Friendly Center</td>
</tr>
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Acknowledgments

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Mike Egboh
Country Representative
Executive Summary

Pathfinder International’s Reproductive Health/Family Planning Service Delivery Project, funded by the David and Lucile Packard Foundation, aims to improve the Reproductive Health (RH) status of adults and adolescents in northern Nigeria, and to increase the utilization of services through a network of public- and private-sector facilities and community-based providers. In the third phase, the project sought to respond more positively to its target communities by conducting a community survey to inform implementation of its future interventions in six states of northern Nigeria (Borno, Kaduna, Kano, Katsina, Niger, and Sokoto) and the Federal Capital Territory. Pathfinder is implementing the project in northern Nigeria to address the region’s depressed socioeconomic conditions and low demand for and use of services, as compared to the southern region.

The community survey used qualitative methods (including focus group discussions, key informant interviews, and in-depth interviews) to elicit information from 511 respondents on their knowledge, practices, and beliefs about RH and Family Planning (FP). It also served to establish the stakeholders’ level of awareness of the project in target communities.

The key findings of the survey include:

- There is good understanding of the concept of child spacing, and acceptance of the concept is growing gradually.
- Barriers to the use of FP for child spacing include religious and cultural concerns and a fear that FP may interfere with future conception.
- RH information is mainly available in urban areas or within the project sites. Radio and television remain the main sources of information.
- Awareness and practice of breastfeeding is common in all states, however the concept of exclusive breastfeeding is not properly understood.
- The goal of child survival is recognized; however facility- and non-facility-based interventions that contribute to child survival are not largely understood or known.
- Across all of the states, awareness is high about HIV/AIDS, its mode(s) of transmission, and some preventive measures; however, awareness may not imply accurate and reliable information.
- There are wide variations in the level of awareness about HIV/AIDS. For instance, knowledge of HIV/AIDS is higher among male youth than among female youth.
- Attitudes towards people living with HIV/AIDS are improving but were generally not positive.
- According to respondents, the Voluntary Counseling and Testing (VCT) services are not readily available across all states. Respondents in some states reported knowing sources of VCT services at public secondary facilities, but few private facilities.
Introduction

Nigeria is Africa’s most populous country, with approximately 135 million people. Northern Nigeria, which contains more than half of the population, encompasses 19 states and three of Nigeria’s six geopolitical zones. The region is predominately Muslim and ethnically Hausa-Fulani, though groups who practice traditional religions and Christianity are found throughout the region.

The northern states of Nigeria are less advantaged than the southern region. The north is characterized by both less demand for and access to reproductive health services.

The level of women’s literacy is exceedingly low in the northern region, especially the North East and North West. About 90% of women have at least primary education in the southern region, but only 25% to 30% of women in the North East and North West have the same level of education. Women’s exposure to mass media is also lower in the northern region.

Both demand for children—measured by the number of children desired—and actual fertility are markedly higher in the northern region compared to the southern region (Figure 1). Women bear about seven children, most of whom are wanted, in the North East and North West, compared to only four children in the southern region. The high fertility in the northern region is a reflection of lower demand for contraception. Only 16%–22% of women in the North East and North West expressed demand for contraception compared to a demand as high as 50% in the South South and South West. On the following page, Figure 2 shows the contraceptive demand pattern by contraceptive use and unmet contraceptive need. It shows that though demand is low in the northern region, unmet need is almost comparable to that in the southern region.

Childhood mortality is extremely high in the northern region, where more than one in four children dies before their fifth birthday. In contrast, one in ten children dies before the age of five in the South East or South West. In an environment of high infant and child mortality, desired fertility remains high; there is no or low demand for contraception and myths and misconceptions about family planning are common. High fertility is a source of mortality and morbidity in both children and mothers, mainly through short birth spacing and resource competition. Therefore, though fertility is high in the north, the high child mortality rate reduces the number of surviving children per family to the same number as in the south.
Child health services also lag behind in northern Nigeria. For example, less than 20% of children received the DPT1 vaccine—a measure of access to child immunization—in the North East and North West. The same indicator is over 80% in the South.

Maternal health indicators also fare poorly in the north. Only 10%-17% of women delivered in facilities compared to over 80% in the South East. Maternal tetanus toxoid immunization coverage is also relatively low in the north.

Some indicators show that the difference in knowledge and attitudes about Sexually Transmitted Infections (STIs), including HIV/AIDS, between women in the north and south is smaller than the difference in their knowledge of other reproductive health issues. However, knowledge and positive attitudes about STIs/HIV/AIDS remain low in both areas. For example, between 30% and 50% of women in the north and between 40% and 60% of women in the south stated that condom use could reduce the risk of transmission of HIV/AIDS. When women were asked if they would buy vegetables from a person who is known to have HIV/AIDS, 20%-35% said they would. This indicator for the North East and North West is comparable to that in the South South and South West. On partner negotiation, 85%-90% women in the North East and North West and about 85% women in the South South and South West reported that it is justified to refuse sex if their husband has an STI.

Pathfinder sees bridging the disparities in health and social services between the north and south of Nigeria as an effective way of facilitating even development throughout the country. Therefore, with funding from the David and Lucile Packard Foundation, in August 2000 Pathfinder International launched the Reproductive Health/Family Planning Service Delivery Project in Northern Nigeria. The project has been implemented in three phases over seven years across six Northern states of Nigeria including Borno, Katsina, Kaduna, Kano, Niger, and Sokoto, and the Federal Capital Territory (FCT).

Pathfinder Interventions

Pathfinder has provided grants and technical assistance to Nongovernmental Organizations (NGOs) to provide services to their communities. Pathfinder has built the capacity of 27 NGOs to offer quality Reproductive Health (RH) and Family Planning (FP) services through a network of over 130 clinics and 5,000 trained Community Based Distributors (CBDs). CBDs include Male Motivators (MM), Peer Health Educators (PHEs), Traditional Birth Attendants (TBAs), Market-Based Distributors (MBDs), and Patent Medicine Vendors (PMVs); the numbers trained are shown in the following table:
<table>
<thead>
<tr>
<th>Type of community agent</th>
<th>Number</th>
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<tbody>
<tr>
<td>Traditional Birth Attendants (TBAs)</td>
<td>2,756</td>
</tr>
<tr>
<td>Peer Health Educators (PHEs)</td>
<td>1,093</td>
</tr>
<tr>
<td>Patent Medicine Vendors (PMVs)</td>
<td>512</td>
</tr>
<tr>
<td>Market-Based Distributors (MBDs)</td>
<td>275</td>
</tr>
<tr>
<td>Male Motivators (MMs)</td>
<td>564</td>
</tr>
</tbody>
</table>

The project assisted each NGO in assessing their clinics’ needs and developing a plan to improve their quality of care. Interventions varied between organizations, but included policies such as institutionalization of infection prevention controls, rewards for good performance, and mechanisms to improve client flow. Most facilities received essential equipment and supplies, such as hospital beds and delivery and examination couches. Three hospitals were upgraded with major equipment including ultrasound and anesthetic machines, enabling them to serve as referral centers for smaller hospitals. In addition, the project trained over 173 doctors and 336 nurses in basic service provision, syndromic management of sexually transmitted infections, and counseling skills. To date, the project has provided 850,000 men, women, and adolescents with RH/FP services through clinic and community providers.

Pathfinder has spent considerable effort training and sensitizing community and religious leaders on RH/FP issues, resulting in supportive relationships with both groups. As a result of work with imams, the document *Reproductive Health Issues in Nigeria: the Islamic Perspectives* was written and translated into Hausa and distributed in collaboration with prominent Islamic scholars. The document has been endorsed by the Supreme Council of Islamic Affairs in Nigeria, and will continue to be disseminated throughout Nigeria. As a result of a Bangladesh study tour, Pathfinder is implementing a training program for imams to address various social sector issues, including RH/FP within their communities. In collaboration with the Enabling HIV/AIDS, TB and Social Sector Environment (ENHANSE) project, Pathfinder has trained 52 imams. Pathfinder’s work with community and religious leaders has also facilitated project implementation, and resulted in greater leveraging of funds to achieve broader RH and other social sector support in the region.

The project created behavior change communication materials that included posters, notebooks, t-shirts, Fez-caps, and FP cue cards. Materials were developed with the involvement of key stakeholders, including religious leaders and youth, to ensure cultural and religious acceptance by the target audience. Sensitization activities included health rallies, home visits, and public health campaigns in mosques, churches, schools, and workplaces. In addition, the project used mass media, including radio and phone-in programs as well as TV spots, to convey RH messages to the communities. Through these efforts, Pathfinder has been able to reach over 13 million people with RH/FP information and messages.

To help other organizations working in the region and facing similar challenges, Pathfinder also developed an action guide for implementation of RH programs in northern Nigeria. The guide outlines problems commonly faced, and shares the lessons Pathfinder has learned in addressing these problems. The project has also looked for ways to provide opportunities for women and youth. As a result of a study tour to Ghana, two youth-friendly centers were established in
Kafanchan, Kaduna State and Katsina, Katsina State. Support for vocational skills training has also been provided to organizations to benefit both women and youth in the target communities.

During the third phase of project implementation (October 2006 - March 2009), the project aims to improve the RH status of adults and adolescents in northern Nigeria and increase the utilization of services through a network of public- and private-sector facilities and community-based providers. Specific objectives include:

- Improve health-seeking behavior and create an enabling environment related to RH/FP;
- Increase availability, accessibility and quality of RH/FP services; and
- Strengthen the capacity of local partners to deliver quality RH/FP services.

Pathfinder conducted a community survey at the beginning of Phase III. Findings will inform implementation of its future interventions in the six states of northern Nigeria and the FCT.
Study Objectives and Methodology

Objectives

The main objectives of the study were to document the following:

- Community-specific norms and values that impact RH/FP service utilization (positively or negatively) in the project sites;
- Community knowledge about RH/FP, including HIV/AIDS;
- Community awareness, acceptance, and perceived achievements of the project and the services it provides; and
- Suggestions for improvement and sustainability of the project.

The community survey sought to answer the following three questions related to the implementation of the first two phases of project implementation:

1. To what extent are target community members knowledgeable about RH/FP and the availability of those services?
2. To what extent are members of the target communities accessing RH/FP services (including facility-based services and CBDs)? In what situations are they seeking services? Are they receiving referrals? What are their opinions of the services they have received?
3. What can the project do to increase the health-seeking behavior of community members, including use of facilities, to improve their RH status?

The findings of the evaluation will inform implementation of future interventions in the six states and the FCT.

Methodology

The study utilized qualitative methods (FGDs, Key Informant Interviews (KIIs), and In-Depth Interviews (IDIs)) to elicit information from 511 respondents in the selected project communities (see Appendix A). The respondents included active participants in the implementation of the project, including project staff, trained providers, and CBDs. There are five main types of CBDs in the project, including Traditional Birth Attendants (TBAs), Male Motivators (MMs), Peer Health Educators (PHEs), Patent Medicine Vendors (PMVs), and Market-Based Distributors (MBDs). For the purposes of this survey, the PMVs and MBDs were grouped together due to their similar project activities and expectations.

Other respondents interviewed included youth (aged 14-24 years), Women of Reproductive Age (WRA), Men of Reproductive Age (MRA), and opinion leaders. Tables showing the proposed and actual sample size and the type of evaluation conducted are provided in Appendix B.
Results

Community-Specific Norms and Values that Impact RH/FP Service Utilization in the Project Sites

Because community norms and practices need to be understood for project interventions to be successful, respondents were asked to describe the norms and practices that might affect their behaviors toward accepting RH services. The following section summarizes the norms and practices as described by respondents.

Child Spacing

There seems to be a set of common community norms across all six states and the FCT. Predominant beliefs revolve around the religious conviction that God has asked people to procreate and that there should be no need to limit or stop childbearing. It is also believed that children are gifts from God, and therefore women should not limit or space their pregnancies. This belief has been strongly supported by Christian and Muslim religious leaders, thus explaining a general disapproval of FP. For example, an Imam in Sokoto said, “We know nobody can determine the size of the family apart from God.” A TBA in Katsina explained, “They believe that God gave you children and will provide for their needs.” A male youth responded, “No one should obstruct the survival of another person, after all the religion preaches that propagation of children is a blessing from God and it is disobedience on the part of anyone who practices family planning.”

On the other hand, some respondents provided arguments that the Quran supports child spacing. It seems that while some community and religious leaders recognize that both traditional and spiritual dictates do not oppose spacing, the resistance to modern FP is due to lack of trust of the motivations of those who promote spacing, as it is a Western practice. “There is clear difference between the saying in the Quran that delivery and nursing of a child should be within 30 months. But in the case of modern child spacing, it may go beyond 30 months. So people do not have trust with Western-oriented issues,” explained a religious leader in Sokoto.

Apart from the religious belief in support of having children whenever a woman becomes pregnant, several community norms encourage people to have many children. In the southeastern parts of FCT, it is common to celebrate the 10th child of a woman. Some respondents mentioned that this norm is still being practiced, even when southeastern women are away from their homeland. A MRA from FCT explained: “I come from area where a woman giving birth to many children is honored with a big ceremony. . . even when they have given birth to 10 children the community will encourage them to have more.”

Having many children enhances the social status of the household head and provides a reliable source of labor for a farming family. In most of the states, polygamy and competition among wives to produce children leads to many children. In some cases, there is high preference to produce male children, and in other cases to produce the highest number of children in the family.
Two norms mentioned discourage the use of modern family planning methods. Traditional methods of FP, including the use of herbs, are common throughout the north and discourage the use of more effective modern methods. Some of these methods include putting fertilizer under the pillow; taking a “pill” made of dried bat’s waste; planting a plant under a pot and when it grows, squeezing it and putting it on the forehead; consuming groundnut leaves; or using “guru” (Medicinal waistband to give protective properties to its wearer). “For traditional family planning, you squeeze lemon juice and drink. Others drink potash (potassium) in water,” explained a WRA in Bama Borno. Also, there is a belief among some people that condoms may not be as effective as the condom promotion campaigns claim.

Some positive community norms have also been noted. In some states, such as Kano, both community members and health facility managers commented that more youth are not only accepting and using contraceptives, but are also more open to discussing RH issues due to increased awareness.

**Maternal Health**

The community named several practices that affect the health of child-bearing women both during pregnancy and delivery, and after birth. In some communities, pregnant women are not allowed to eat certain meals or foods. For example, in Borno, pregnant women are not allowed to eat eggs because there is a belief that if she does, her child will grow up to be a thief.

Across the northern states, the study revealed that unattended labor and delivery is a common practice. This means that the pregnant woman delivers the baby herself in her home, and then may ask for assistance in cleaning the baby or removing the placenta. The women explaining this practice gave insights to the reasons why women do not attend a hospital for delivery. Some opined that husbands may prohibit their wives from going to facilities because of the purdah system, which is an Islamic tradition secluding married women from other men. Others said that it is mainly because of financial implications involved in using health services. Other women may not go for Antenatal Care (ANC) due largely to a lack of understanding of the value of a health facility over what a TBA will offer. Therefore, this practice constitutes the high use of TBAs and explains the low utilization of health facilities for delivery.

Some women mentioned that the practice of “tsagar gishiri” is done to women during child birth. *Tsagar gishiri* or *yankan gishiri* is a traditional episiotomy done by TBAs using a razor blade. It is performed during obstructed labor, especially in premature births. The cut is made upwards towards the urethra, and is a primary cause of vesico-vaginal fistula, which can also be caused by prolonged labor before referral.

Another practice is called “wankan jego” in which the new mother is given a hot bath using leaves of the neem tree twice a day for about 40 days following delivery. The leaves are usually dipped into boiled water and splashed on the body until the water runs out. Although the hot water massages the body and many women say the bath makes them feel good, if overdone, it can raise the woman’s blood pressure.
There were also some positive practices mentioned in most states that promote good maternal health behavior. There are increased instances of women delivering in the hospital, compared to the historical resistance to hospital delivery in many project areas. Respondents also mentioned norms that support child spacing, such as when husbands send their wives to stay with their families soon after birth to prevent becoming pregnant too soon after giving birth.

**Child Health**

Norms and practices around nutrition and circumcision of children affect their health in both positive and negative ways. Breastfeeding was mentioned as a common practice in all the states and its value to the health of the child was described. For example, a TBA in Katsina explained, “If a woman delivers, we don’t advise her to give the baby ordinary milk because there is danger in giving the milk to a child when the baby is sucking the breast... So the best thing a nursing mother will do is to give breast milk to the baby.”

However, there were some breastfeeding practices mentioned that indicate that exclusive breastfeeding is not always the norm across the states. Several respondents described the traditional way of feeding newborn babies, which was to feed them with fresh cow milk for three days then later change to the mother’s breast milk. According to a TBA in Sokoto, the breast milk is first tested as follows:

> “After three days we get a shoe and burn it, then we ask the woman to pull her breast so that the breast milk will drop on top of that shoe. If the breast milk runs down from that shoe, the baby will suck the breast because that running away by the breast milk shows that the milk is good. But if it stays on the shoe, it means there is problem and the baby will not be allowed to suck that breast milk until after the mother takes some herbal concoctions.”

Another nutrition-related practice is not giving children eggs, fish, or goat meat. It is believed that children should not eat eggs as the child may steal in the future; that if a child eats the head of fish, it becomes dull; and that giving children goat meat will give them rashes and leprosy.

Male circumcision is a very common African practice, however in some parts of the north such as in Katsina State, it is normally carried out by local barbers called “wanzami” when the child turns seven years old. This practice was also noted in the Shuwa Arab tribe of Borno State where female genital mutilation is practiced. “Traditionally, it is taboo to circumcise a child less than one year old. Additionally, female children are circumcised believing that if she is not, there is tendency of not enjoying sex with her husband,” described a WRA in Katsina.

**HIV/AIDS**

Respondents mentioned a few community norms related to HIV/AIDS. One respondent mentioned a cultural celebration of virginity as one way of delaying the onset of sexual relations and preventing the transmission of sexually transmitted diseases as a practice in some parts of the north. Also due to greater awareness of HIV and AIDS, girls are now demanding to know the HIV status of boys before accepting a marriage proposal. Friendlier attitudes towards People Living With HIV/AIDS (PLWHA) are also being noted in the communities.
Communication

Parent-to-child or spousal communication on RH issues is still generally challenging in most states. A MRA in Katsina explained, “...sex is a difficult topic to be discussed by parents and children.” Respondents noted a particular stigma associated with free and open discussions of FP among the population in Sokoto. A female youth in Sokoto said, “Parents are traditionally shy to discuss issues relating to child spacing especially with their eldest daughters.”

Respondents described patterns of communication among parents and their children, typically from mother to daughter and father to son. However, in Niger State, tradition accords a measure of respect on the first male child and therefore his parents find it difficult to discuss issues like RH/FP with him.

Respondents described factors that both encouraged and discouraged communication in their communities. Factors that encouraged communication included higher education, greater awareness of RH issues (due to media attention, clinic health talks, sermons by religious leaders, and home visits), love and understanding of partners, leadership skills of fathers, and the reality of increased incidence of STIs, including HIV/AIDS. Respondents were unanimous in mentioning level of education as a major factor in promoting spousal and parent-child communication. “In a family where they are educated, they do discuss with their children freely and advise them on such aspects of family planning, HIV/AIDS disease and so on,” explained a PHE in Katsina. According to TBAs, spousal communication is taking place after these women have met with CBDs (such as TBAs). “Yes, many people do discuss such issues, because most of the women do tell us that this is what my husband said, or what I discussed with my husband and when we met with the husband, he will be laughing because he knows the wife has contacted us on the issue,” said a TBA in Katsina.

However, most admitted that parents are educating their families on RH topics, particularly HIV, due to the fear of death. “They talk about HIV/AIDS because it has shortened the lifespan of many,” said a PHE in Kaduna. “In Islam, you find it somehow difficult to sit down with your daughter or son and start discussing things like this, but with the state of things now, it is important we embrace it [parent-child communication],” a MRA in Niger explained.

The factors mentioned that inhibit communication include attitude and decision-making power of the men, shyness, poverty, lack of access to mass media, misunderstanding between spouses and misinformation about RH. A female youth in Katsina said, “Family planning is not a commonly discussed issue between parents and their children because of shyness. Most parents deem it as inappropriate to talk to their children on the use of contraceptives, injectables, and other FP methods because they fear the children may misconceive that as a license to embark on premarital sex.”

Decision making is a major issue in communication that was explored by the study. It was unanimous in all the states that the husband, father, or male head of the family had absolute decision making-powers in all matters concerning his family, including RH issues. A MRA from Kaduna emphasized that “Many parents have negative responses towards engaging their
children in [the] decision making process. ” During labor and delivery and sometimes in cases of complications, other secondary players (such as parents or in-laws) may make an important decision for the family. Rarely will the woman delivering make decisions, even regarding her own health.

Community Knowledge on RH/FP, Including HIV/AIDS

The level of knowledge of respondents in each state varies significantly depending on the different RH issues being investigated. Respondents reported that the various sources of information about RH in their communities are radio, conferences, workshops, lectures, seminars, friends, Non-Governmental Organizations (NGOs), dramas, pamphlets, and TV. The main sources of information remain radio and TV. Some respondents observed that information on child spacing, child survival, and HIV/AIDS is mainly available in urban areas or in project sites, as is the case in Sokoto and Niger States.

Child Spacing

Respondents’ perception of child spacing also reflects a gradual growth in its acceptance in all states, and suggests that as more accurate information becomes available, myths about child spacing are becoming less common. A TBA in Maiduguri explained child spacing as “...planning the number of children you want and putting gap between each child.” Most respondents, such as a TBA in Katsina, attributed the acceptance of child spacing to enlightenment and awareness campaigns, which have increased acceptance of it even within the context of an Islamic environment where public health campaigns (such as polio vaccination campaigns) have historically been controversial. In addition, the economic reality faced by parents of providing for their families (including paying for the cost of services rendered during childbirth in a hospital) has played a part in the growing acceptance of FP. Some respondents in Kaduna mentioned the reduced number of children born in their communities as evidence of the increased acceptance of child spacing.

Because in the past, the main controversies around child spacing campaigns were due to the promotion of child limiting, the distinction between child spacing and child limiting was sought from most of the community members. The respondents in most cases were able to distinguish between the principles of child spacing and child limiting. For example, a MRA in Katsina described limiting as “...restricting pregnancies based on agreement between couples, while spacing has to do with maintaining a certain gap between pregnancies.” However, some in Katsina felt that child spacing is only necessary or important in polygamous settings where, explained one youth, “a man can father so many children beyond his capacity.” In general, each time the issue of child limitation was discussed, the issue of spousal consent was emphasized by respondents.

The advantages of child spacing are aptly stated by a MRA in Katsina which encapsulates the essence of increased knowledge and appreciation of child spacing: “Child spacing can be seen from three perspectives: mother, child and father. [For the] mother, it ensures that her health is looked after by avoiding too frequent pregnancies. [For the] child [it means] good upbringing
Despite good understanding of the concept of child spacing and its advantages, use of contraception may still be low because of religious and cultural barriers. Some expressed hesitance in adopting child spacing methods as they fear it may interfere with being able to conceive when the woman desires. One respondent said, “…there’s the belief that when you take family planning pills you will not give birth forever even when you discontinue taking the drugs. They prefer to take herbs (traditional medicines) rather than drugs.”

Child Survival
The goal of child survival is recognized as important, however facility and non-facility based interventions that contribute to child survival are not largely understood or known. Some male youth claimed that child survival has to do with fear of having a child outside of wedlock or unwanted pregnancy. Some mothers, TBAs, and leaders were knowledgeable about ways to improve child survival (including ANC, immunizations, home hygiene, breastfeeding, oral rehydration, good nutrition, FP, and education). However, in some states such as Katsina and Kaduna, even WRA could not clearly display a good understanding of the major actions that may increase the survival of a child. All were aware of the importance of breastfeeding, and supported breastfeeding for a period of six months to two years. (However, it is important to note that this does not necessarily indicate support for exclusive breastfeeding, as the general practice is to give water in addition to breast milk for four to six months, and then introduce other foods.)

HIV/AIDS
The survey findings revealed a high awareness of HIV/AIDS in all states, including its mode of transmission and some preventive measures. A male youth in Bama Borno described HIV/AIDS as “…a disease that is worldwide, spread through sex, and it has no cure.” In FCT, Sokoto, and Kaduna, respondents were able to display a reasonable understanding of prevention of mother-to-child transmission and its implication for child survival. There are some instances that the high level of awareness may not imply accurate and reliable information on HIV transmission and prevention. There are also variations in the level of awareness within and between the adult and the youth groups. In Niger and Kano states, the male youth seemed more aware and quite knowledgeable about HIV and AIDS. Female youth seemed to know very little about HIV.

It is worth noting that in Niger, Kano, and Kaduna states, some are still not convinced that HIV and AIDS are real. A MRA in Katsina explained, “Some people still don’t believe [HIV] exists in the community, especially in the rural areas.” Respondents vary in their perception of why it is not real, with most believing that HIV is Western propaganda. According to a PHE in Kano, many in the community think that “…HIV/AIDS is a kind of Western disease and not an African disease.” It is believed that according to religious teachings, there is no sickness for which God has not provided a cure. Therefore, some people believe that there is a cure for HIV/AIDS.
The opinion of many respondents was that HIV is a disease spread by and afflicting particular groups in the community, such as youth, people who are promiscuous and/or unfaithful, and travelers. Many in Katsina felt that HIV is a problem emanating only from indiscriminate sexual relations and is mostly associated with unfaithfulness. In Borno State in particular, any individual suffering from HIV/AIDS is regarded as promiscuous. A male youth in Sokoto reported “The respondents heard about HIV/AIDS through the electronic media. ...anyone with diarrhea and vomiting is suspected of having the disease, especially if the individual is a traveler.”

It is important to note that attitudes towards the PLWHA may not be generally positive. Some respondents commented that they think the PLWHA in their communities will soon die, and this frightened them.

Community Awareness, Acceptance, and Perceived Achievements of the Project and its Services

Awareness and Acceptance of Facility-Based Services

The survey sought to determine if the project is known by its target beneficiaries and if the project is well accepted. In Niger, Borno, Kaduna, Sokoto, Katsina and parts of Kano State, the project is well known and patronage is reportedly high. Awareness of the project is lowest in FCT, mostly because the project worked with only two NGOs in FCT, one of which provided only facility-based services. Youth in the target areas of FCT are mostly unaware of the project and the CBD and Voluntary Counseling and Testing (VCT) services it provides.

It should be noted that in the following discussion of strengths and weaknesses of facilities, that respondents have given feedback on their impression of overall RH/FP services being provided within their community, which includes both project and non-project supported facilities. Not all respondents were aware of which facilities are being supported by the project and, in some cases respondents could not and did not distinguish between project and non-project facilities when making comments about health services in their communities. However, participant feedback will assist in identifying what the community perceives as important in services being provided, which will in-turn influence project interventions.

Kano

The major complaint of respondents in Kano State was the poor attitudes of service providers, especially at tertiary institutions that serve as referral centers for some project sites. It is important to note that the respondents did not make clear distinctions in all discussions whether they had experienced poor provider attitudes only at the tertiary institutions, or at all health service levels. Equally important to note is that the project did not partner directly with tertiary institutions in Kano State. However, the following comments made by MRA are important for project implementation and strategy development:

- “The doctors at general hospitals are not punctual. They come in late and close early.”
- “They [providers] don’t keep secrets. For instance, when someone is tested [for] HIV/AIDS and it turns out to be positive, before he knows it, everybody is aware.”
• “They [providers] sometimes ignore emergencies... That is why some people prefer to go to a chemist.”

• “Prolonged labor is caused by some nurses because they don’t attend to those who did not have their antenatal [care] in the general hospital. They refer them back to the hospital where they did their antenatal [care].”

Male youth in Kano noted a number of issues affecting the quality of service delivery in their communities. According to them, some doctors and providers do not attend to all clients for unacceptable reasons, such as:

• “Some doctors only attend 20 patients per day. Even when emergencies are brought to them, they refuse to see the patients because they will say they are through for the day. As such, you may find patients spending two to three days without seeing a doctor, which is not proper and fair.”

• “Women most especially have these problems with nurses especially during giving birth, postnatal [care], and antenatal [care].”

• “They [government hospital nurses] also show differences [in the treatment they give] between the rich and poor... unlike in private hospitals were every patient is treated equally.”

Other challenges in Kano State include lack of medical equipment, inexperienced service providers, insufficient Information, Education, and Communication (IEC) materials for campaigns (such as posters), inability to locate referral centers, high cost of services and frequent stock-out of drugs. One MM said that “We have young doctors that are not well experienced.” Another explained, “At times the medicine is not available in the hospital. You have to go outside the hospital to buy [it].” Respondents generally felt that VCT services were not available in their communities or they were not aware these services are available at all.

Borno

The majority of the respondents in Borno State indicated that they are accessing the services provided by the project facilities. Respondents noted that utilization of contraception is higher in the urban areas than in the rural areas, despite the presence of CBDs. However, the level of acceptance of FP is reportedly higher after the project’s intervention than it was previously.

It was felt that the project sites have enjoyed overall support from the community. However, a few comments were made about the inadequacies of the facilities. There is a need for more space within the facilities to ensure privacy. Mosquito nets are needed to protect clients from malaria. The facilities do not have an alternative power supply and water supply is unavailable to clients. Other issues include drug stock-outs and long waiting periods.

Kaduna

In Kaduna, there are skilled, competent, and neat providers in the clinics who are judged to be very friendly. Posters, handbills, and video cassettes were mentioned as tools that have helped the project expand. However, some important project issues were mentioned by the respondents.
The clinics lack good storage facilities, they are far from the clients they serve, and providers have poor interpersonal communication with clients.

In Kaduna, male youth mentioned the Youth-Friendly Center (YFC) at Takau Progressive Association (TPA) Kafanchan. They said the center makes the youth self-reliant and self-sustainable. Youth benefit from entertainment and recreational activities provided in the center while providing information and services on RH/FP. They also commented that the concept of having a YFC is a welcome development, since it is producing the desired effect on the attitudes of youth toward RH/FP. TPA also provides services for the community at large, including provision of oral re-hydration therapy, contraceptives, and counseling services on HIV and STIs. In addition, adults can learn hand crafts, hairdressing, how to use computers, and participate in recreational activities. They felt that youth have benefited immensely from these activities as some have been engaged in hand crafts and are now self-reliant.

Niger
In Niger State, respondents knew that services were available at project supported facilities. The providers at the centers were applauded by most respondents as skillful, friendly, hardworking, and always ready to attend to clients, while “carrying out their job diligently despite limited resources.” It is important to mention that several respondents did not approve of the selection of one of the service sites because the facility lacks adequate space for the large population served by the facility. The clinic has only two beds, the site lacks privacy, and there are few staff and no qualified doctor. Youth noted poor attitudes of providers towards respecting young clients’ confidentiality. Other issues noted include inadequate equipment (e.g., no ambulance in case of emergency referral), occasional drug stock-outs, and that the drugs prescribed by some doctors are often not known at community pharmacies.

Some of the respondents (particularly CBDs) claimed to be unaware of VCT centers in their area, while many others were aware of existing services. The Taimako Youth Centre was mentioned as offering recreational services for youth. The center includes games, counseling and referral services for RH/FP, enlightenment programs, skill acquisition, computer education, and tailoring and knitting instruction.

Sokoto
Respondents named a number of issues that affect facility service provision in Sokoto State. These include insufficient or nonexistent facilities, services (including immunization), equipment, chairs, and drugs. In addition, it was noted that there is low acceptability of newly-trained TBAs, and that there are no salary or incentives available to them. A lack of adequate personnel, a high level of illiteracy among the population served, unnecessary transfer of staff due to political differences, and lack of electricity and water were also listed by respondents as concerns.

Two respondents described the transportation situation as such:
• “We decided to raise money to fuel a car owned by hospitals to carry people from far places when the need arises. We started raising funds for this purpose, yet we could not make it.” (Chief Imam)
• “You may have a woman in labor, but sometimes you need to trek to rescue her life.” (Health provider)

Respondents also noted that the project-supported health center in Durbawa is the only health center in the village. This center does not have a resident doctor. A doctor visits the center once every two weeks. A PMV noted that “We need more PPFN [Planned Parenthood Federation of Nigeria] centers in villages.” A community leader explained that “…immunization services are not available in the community, so women travel to Sokoto (the capital city) for that.”

Youth respondents noted a lack of youth-friendly centers and respondents identified only one VCT center in the area.

Katsina
In Katsina State, respondents mentioned the same problems as respondents in Sokoto. In addition, they mentioned the unavailability of VCT centers, an occasional lack of confidentiality, lack of female providers, and long waiting times at health facilities. Several youth also commented that the facilities need renovation. The MMs in Katsina do not have a good impression of the facilities, especially the public centers. They commented that the hospitals are mostly overcrowded, equipment is insufficient, and provider attitudes are poor.

Respondents commented on one project-supported center that the staff is good, skillful, and courteous, and the facility is clean and strategically located. A MRA said that “…equipment and commodities have improved,” since the project intervention.

Many respondents want clinic hours at one of the project-supported facilities to be extended to the evening, but the youth prefer morning hours. The clients have problems with one of the hospitals offering RH/FP services because it has no security guard, dirty toilets, and lacks drugs.

Respondents reported that VCT services are available in Katsina. Government secondary facilities offer counseling and testing for HIV. However, some other private and public centers offer only counseling services.

There is at least one YFC in Katsina. In addition, the youth respondents mentioned football grounds, snooker or billiards centers, and picnic areas as examples of areas where youth are able to access recreational facilities while receiving information on RH/FP and referral for services. However, they commented that these centers are in disrepair. They are mostly owned by government with very little private ownership.

FCT
In FCT, the respondents mentioned one non-project facility in particular, as needing improvement. Major comments related to the poor state of the center, including lack of qualified and dedicated personnel, inadequate facilities, poor services, the nonchalant attitude of some health providers, and inconsistency in service delivery due to strikes. Explained two MRAs:
• “[It] is a no-go area. One can see before now [there was a] refuse heap but now [the] government is trying and they are clearing the refuse along the road. Another thing is that sometimes they say they are on strike. Even if you bring somebody there for treatment they will say they are not working because they are on strike.”
• “There is no attention. If you go there, there are no drugs in their pharmaceutical store. Most of the time they write drugs for you and tell you to go outside to buy.”

There is a strong preference for the private service sites because, as one WRA in FCT said, “They are neater, providers treat clients better and have good attitudes, and the clinics are there to attend to clients at all times.”

Some respondents noted that VCT is only available in the general hospital and only some respondents were aware of any youth-friendly centers in the project communities.

**Roles and Perceptions of Community-Based Agents**
The survey sought to understand the roles of the CBDs in the communities and gather community opinion on which community-based approach seemed to have been most effective in the project areas.

**Peer Health Educators**
The PHEs are the main CBDs trained specifically to provide services to youth within the community and in schools. PHEs are selected in consultation with relevant community leaders and their peers. They are trained to conduct one-on-one and group talks on RH/FP and, in some instances, provide non-prescriptive methods for FP. PHEs serve an average of 50 to 100 persons per month. Respondents said the duties of the PHEs include the following:

- Educating youth on the negative effects of unprotected sex,
- Counseling students on HIV/AIDS and other STIs,
- Working with PLWHA to reduce stigmatization, and
- Follow-up of clients to determine the extent of facility utilization.

The PHEs said that they advise clients to practice abstinence, and if the client cannot abstain, then they recommend the use of condoms.

In many areas, PHEs are considered successful agents because they were able to change the level of awareness among their peers, particularly at school and during club meetings. However, high turnover made some respondents consider them ineffective.

Across all the states, PHEs reported that the community members appreciate the valuable contributions they make. According a PHE from Kaduna, “…only a few show no interest.” A PHE in Kaduna explained “…in school where you are called for lecture, the students are kind of interested but you have to create a kind of motive for them. We do some follow-up, because [when a client is] referred to a particular health centre, it is your duty as a peer educator to follow-up and make sure [your client] goes and gets that service.” However, community perception is a major challenge that PHEs in Katsina are facing. They are not able to educate
some women on FP due to negative perception of their character by female community members.

PHEs in Kano listed some of their challenges as the high cost of services to young clients, lack of equipment/commodities at the health facilities, lack of services offered at a convenient time for young clients, and distance of health facilities from clients. PHEs in Kaduna complained of a lack of microphones for IEC events and not enough facilitators to support the project. They also asked that the project provide motorcycles or bicycles to ease transportation costs and uniforms.

**Traditional Birth Attendants**

The project identified women currently working as TBAs and trained them in ante- and postnatal care and safe delivery practices. They serve mainly pregnant and postpartum women, and attend an average of three to eight deliveries per month. Respondents described the TBAs duties as the following:

- Providing home delivery services through both modern and traditional methods;
- Ensuring a safe delivery;
- Ensuring good health conditions for both the mother and her baby;
- Providing postnatal care services;
- Counseling and assisting pregnant mothers on reproductive health, food and nutrition, and breastfeeding;
- Observing the physical and psychological features of the pregnant woman and making appropriate recommendations; and
- Providing referrals.

TBAs described their services as including ANC and postpartum services in addition to attending deliveries. Many of the TBAs reported that they also follow-up with their clients after each delivery. Most TBAs record ANC and delivery data regularly. TBAs in Kaduna reported that they also use referral notes written by the health provider.

All TBAs displayed a good understanding of labor and delivery complications, and infection procedures appear to be adhered to (such as discarding blades used during delivery and wearing gloves to prevent infection). TBAs reported referring cases beyond their capacity, including those involving conditions such as breach presentation, prolonged labor, swelling of the leg (edema), anemia, severe hemorrhage, frequency in vomiting, severe lower abdominal pain, preeclampsia, and/or severe headaches to higher level facilities. A TBA in Sokoto explained how a mother is monitored during and immediately after delivery: “When she delivers, I quickly take the child and show [it] to her and ask her if the baby is a female or male. When she recognizes the sex of her baby then I thank God that she is in her senses. But if she couldn’t recognize the sex of her baby, then I quickly rush her to hospital.” TBAs reported that they often accompany clients to the referral centers. However, they note problems with referrals to facilities, particularly postpartum. Explained one TBA from Katsina, “…in situations where a woman gives birth at home and is later taken to the hospital, such woman will not be given serious attention... they will be blaming the woman — why did she refuse to come to the hospital in time?”
Respondents identified TBAs as the best-performing community agent because of their significant role in reducing maternal mortality. According to a community leader in Sokoto, the reason for the popularity of TBAs in most of the communities is that “…there’s a very good relationship between health providers and the community. The only problem is that our people want workers to meet them at home and treat them.” TBA agents are also considered most successful because they are more organized, meet regularly, and conduct home visits.

TBAs in Kaduna gave reasons why women prefer TBAs’ services over facility services, including:

- “It is convenient, affordable, and cheaper than hospital delivery.”
- “Some clients cannot afford hospital delivery due to distance and cost of transportation.”
- “Facilities give a list of items for expectant mother to buy and bring for delivery. But in the past such [things were provided] free.”
- “Because of the poor state of roads during rainy season.”

There is also a high level of satisfaction with the services TBAs provide. A TBA explained, “People are confident and satisfied with our services.” Another said, “We establish interpersonal relations with our clients.” In fact, the Ministry of Health has recognized the value of TBAs, which has helped to increase their job satisfaction as well as their credibility. The impact of TBA training was acknowledged by all, including the local authorities. In Sokoto State, the local government association is seeking to provide some assistance to the TBAs, but has not yet been successful. However, while the work of the TBAs is seen to be valuable and important by many, others see them as propagating western cultural ideals.

**Male Motivators**

Male motivators are usually between 30-45 years old, gainfully employed (i.e., traders, drivers) and serve as motivators for men to accept and utilize RH/FP services. The MMs described their roles to include educating the community about diseases like HIV/AIDS and malaria, and advising clients to avoid unprotected sex. Other duties include encouraging immunization of children, educating women about ante- and postnatal care, participating in health awareness campaigns, and providing referrals to service delivery centers. Katsina MMs report that clients prefer non-prescriptive FP methods such as pills and condoms because premarital sex is very common among youth, they are satisfied with the method of prevention and control, and they feel they are safe from contracting the HIV virus. They often serve both males and females in the community including youth, married men and women, market women, and traditional leaders.

A Kaduna MM explained, “I enlighten both males and females on the importance of immunization…I discourage their shared [harmful] common beliefs and practices on child bearing and child welfare.” A MM who travels frequently by bus mentioned that he engages community members on the buses and everywhere he goes. Another MM from Borno explained, “…after the training we received, I need to visit my village at the market days and teach them the gospel of HIV/AIDS prevention, and that is why they wait for me every market day and even some ask me if I will be coming next week.”
Generally, MMs claimed to be comfortable with their work since they are trying to save lives. Also some mentioned that interaction with the community members has afforded them insight into community problems. MMs say they are faced with two challenges: reducing the effect of illiteracy in their communities, and countering common traditional beliefs and practices about FP and child immunization services. A MM from Katsina explained, “...most people perceive our role as contributory to effective family planning/spacing and also helpful in preventing the spread of STIs including HIV/AIDS. Others, however, see us as agents of Western imperialism spreading anti-Islamic concepts in the community.”

Market-Based Distributors and Patent Medicine Vendors
MBDs and PMVs are mainly men who own small drug stores selling mainly over-the-counter drugs. They are the most popular health care providers, especially in the rural areas.
Respondents described the roles of MBDs and PMVs as:
- Providing drugs and FP commodities;
- Giving advice on FP, abstinence, ANC, postnatal care, immunization, and nutrition;
- Conducting mobilization and education activities;
- Referring community members to project clinics or to general hospitals; and
- Counseling clients individually and in groups.

Some PMVs mentioned that they use posters printed in both English and Hausa in their campaigns. According to the MBDs and PMVs, they serve everyone. “All categories of people come to buy medicine in our places, ranging from children, adults, men, women, and old people,” explained a PMV from Sokoto. In Kaduna State, not all of the PMV respondents displayed knowledge of the project or its activities. In some states, the lowest-performing community-based agents are the PMVs because they are mostly profit-oriented and, due to poor incentives, are not fully participating in project efforts. But in Katsina, the MBDs are reported to be very effective because they serve more clients. Similarly, in Niger State the MBDs are considered the most successful community agents because they have more referrals, have been able to reduce religious barriers (i.e., women in purdah are now attending clinics), and because most of the MBDs are Muslims.

Overall the PMVs and MBDs find their job very encouraging and satisfying. However, they mentioned several challenges to their work. In Sokoto, the challenges included:
- “People don’t want to go to the hospital. They only buy medicine without prescription from the health provider.”
- “Some medicines expire before the expiration date.”
- “The medicine hawkers... they are mobile, most of them are illiterate and nobody trained them.”
- “Most of the married couples don’t do things without consulting each other.”

In Kaduna, the challenges include drug abuse by clients, in that the clients often overdose or use the same drugs for many reasons. Authorities also accuse MBDs of dispensing prescription drugs
illegally. Other challenges include client misunderstanding and misinterpretation of the information given, and stigmatization of HIV and other diseases. One MBD said, “Some people take medicine without following the directions given by the medicine seller. But in such condition when any problem arises, we only send them to the hospital.” “[Clients with] some types of ailments don’t want come out publicly for assistance…stigmatization of HIV clients prevents them from being referred,” said another. In all states, the PMVs and MBDs’ record keeping was noted to be very poor.

**Perceived Achievements of the Project**

Respondents report the project has been useful, responsive, and informative. For example, according to the leaders in Katsina, it is because there is a significant improvement in ANC and immunization acceptance. In Sokoto, reduction in maternal mortality and success in increased ANC attendance and utilization of health facilities are the main reasons. “Before [this project], you hardly saw pregnant women coming here for treatment. But the project used traditional midwives to enlighten women house by house, and we experienced a lot of development,” explained a religious leader from Sokoto.

When asked about sustainability of the project, a number of the respondents thought that the project efforts would continue, regardless of any additional support. They believed this is due to the fact that CBDs have been trained and that the project has involved the community members as implementers. One community leader from Borno said, “The approach is different because of the involvement and participation of the people. Some of them are already nicknamed ‘small doctor.’ This shows that people will continue to come to them to seek information.” Another explained, “We have empowered quite a number of people with knowledge on reproductive health and family planning. This knowledge cannot be taken away from them and since it is related to their health, it will be sustained.”

**The Community’s Perceived Achievements of the Project**

Community members identified the following as achievements of the projects:

- Improved knowledge of RH, FP, and HIV/AIDS;
- Increased acceptance of PLWHA;
- Increased use of services, including FP, RH, HIV/AIDS, and delivery;
- Increased use of contraceptive methods for both STI and pregnancy prevention;
- Increased use of positive health-seeking behaviors (girls asking men to test for HIV/AIDS before marriage, waiting until marriage for sex, reduced indiscriminate sex, delayed marriage, etc.);
- Increased access to affordable and high-quality RH/FP/HIV/AIDS/child survival services through clinics and CBDs;
- Strengthened referral linkages between CBDs and health facilities;
- Increased acceptance and support (including financial) of project services from community leaders, community members and religious leaders;
- Improved economic status for those involved in skill-building and income-generation activities;
- Increased communication among community members of RH/FP issues;
- Reduced number of births, particularly unwanted;
- Reduced maternal and infant mortality and maternal morbidity; and
- Reduced number of new HIV/AIDS cases.
Suggestions for Improvement of the Project in the Future

The goal of the community survey was to identify community norms, practices and beliefs that affect overall acceptance and utilization of RH/FP services. The results from the community survey will assist in the design of appropriate interventions during the third phase of the project. Below is a list of key suggestions for improvement from respondents of all states:

1. Increase the number of education/awareness activities via radio, television, and in the communities about RH issues to reach community members, and community and religious leaders. This should include producing and distributing more IEC materials, jingles, and TV programs on the project goals using local languages.

2. IEC materials and awareness activities should address parent/child and spousal communication, as well as HIV/AIDS stigma reduction.

3. Expand the number of project and service sites (VCT, YFS, immunization, ANC), especially in rural areas and in areas with high demand.

4. Recruit and train additional CBDs and providers, as well as provide refresher and additional training to current CBDs and providers to enhance knowledge and skills.

5. CBDs should be provided with additional incentives, transport or transportation stipends, items that identify them as part of a project (ID cards, t-shirts, caps and/or banners), and IEC materials or other supplies (such as TBA delivery kit supplies) to more effectively carry out their work.

6. Facilities should be renovated and provided with adequate equipment and supplies.

7. Contraceptives, drugs and services should be provided at no- or low-cost.

8. Continue to mobilize and involve religious, government and opinion leaders in the project and in supporting positive RH/FP behaviors.

9. At all service levels, consistent supervision and monitoring of activities should be undertaken and improved.

10. Transportation and referral systems should be improved in the target areas, particularly for emergencies.

11. Communities should be mobilized to provide financial assistance to run the project, such as sourcing drugs, supplying TBA kits, and procuring equipment for health facilities.

12. The project should encourage and establish vocational skills training for women and youth, including girl’s education and mass literacy classes for women. This will help towards economic empowerment to pay for RH/FP services and increase decision making powers within the family. A microcredit program for women would also be a welcome addition to the project.
Conclusion and the Way Forward

The community survey has provided valuable information to answer the questions sought by the project. The following section presents a summary of survey findings for each evaluation question, and describes how the findings are being addressed in Phase III of the project.

To what extent are target-community members knowledgeable about RH/FP and the availability of those services?

The survey revealed that within project communities, most respondents are knowledgeable about RH in general, and particularly about HIV. FP and child spacing were widely recognized concepts, and the acceptance of them has grown within the communities. As a result of brainstorming, campaigns, sensitization, and mass mobilization, a clearer understanding of the health benefits and religious interpretation of RH/FP services have led to more accepting interventions contributing to an increase in utilization of RH services. A majority of respondents, if not all, could identify sources where they can access various FP services.

Despite these achievements, the project has much work to be done in this area. Very few respondents were able to identify VCT services in their communities; those who were aware of VCT services were most often community agents, project managers, or youth. Respondents also displayed low levels of knowledge about the concept of child survival. Issues of religious and traditional beliefs still impede total acceptance of child spacing, especially with regard to modern FP methods. Also, several community norms and traditions affect acceptance and use of services and health RH behaviors in the communities. There are many community norms and traditions that continue to have strong influence on community members’ acceptance and ability to access RH services. Some of these norms and traditions hinder the performance of project partners and agents in promoting increased access to quality RH services in target communities.

To what extent are community members accessing RH/FP services (facility and CBD)? In what situations do they seek these services? If referred, what they think of the services?

The study revealed that all the components of the project have been utilized by the community to varying degrees. Most of the facilities in the rural areas are lone facilities that have greatly benefited their target communities. Several respondents noted that conditions at the facilities have improved, particularly in terms of provider capacity and availability of supplies and equipment. The presence of TBAs also provided support in those communities. In fact, the Ministry of Health’s recognition of their valuable work has further increased their credibility in their communities. In all parts of the north, community agents continue to provide valuable services, bridging the gaps between service delivery points and the general population.

The survey found that all community agents (except TBAs) are performing the same services, including counseling all prospective clients, mobilizing them for services, and campaigning for safer sexual behavior. Therefore, it can be inferred that people in the target communities may not be able to observe or understand the various distinctions in the different types of community
agents and the unique services they are supposed to provide. Also, some CBDs, particularly PHEs and male motivators, noted that community members have demonstrated a negative reaction towards them. Respondents also mentioned many weaknesses in facility service quality, including lack of drugs and equipment, poor provider interactions, lack of transportation to the health facility, and inadequate facilities and providers relative to community demand.

**What can the project do to increase health-seeking behaviors of community members, including use of facilities, to improve their reproductive health status?**

The survey revealed a number of suggestions for how the project might increase health-seeking behaviors of community members. Key among them was continued IEC events, workshops, and advocacy with community members, religious and community leaders, and other key stakeholders to address key topical issues and how they fit with existing norms, traditions, and practices. Because many of the barriers are the result of religious beliefs, it was felt that religious leaders should be encouraged to teach aspects of Islam that endorse child spacing, ANC, and child survival strategies. Also, culturally-sensitive IEC materials should be developed in local languages and widely distributed to complement the project’s educational events. These events and materials would reinforce earlier educational and advocacy efforts of the project, as well as address additional topics needing discussion in the communities (such as parent to child or spousal communication, child survival, and HIV stigma).

Another key recommendation is to improve quality of service provision at both the facility and community levels. Regular training of facility and community-based providers was recommended, as well as provision of incentives to providers, especially those that are performing well. Improvement of facility conditions was also suggested. A periodic audit of facilities and service providers, which would help identify areas that need improvement, enhanced supervision, and collaborating with local stakeholders on facility improvements may be ways in which the project can work to improve the services provided in the facilities.

Particular attention is required to increase knowledge and practice of child survival strategies. It is important to broaden the range of services to include promotion of exclusive breastfeeding, growth monitoring and promotion, and control of childhood endemic diseases like malaria and diarrhea. In addition, free basic drugs and immunization against the six killer childhood diseases should be provided under the Integrated Management of Childhood Illness program.

Another issue in need of attention is the use of FP and child spacing terminology in these areas. Katsina state has seen positive reactions towards the use of the ‘family spacing’ terminology. The project may want to investigate the most culturally appropriate terminology for its use.

Finally, a key recommendation was to continue to make these important health services available and accessible to more people. In particular, the project could work with the appropriate State Action Committee on AIDS (SACA) to establish more VCT centers in all target areas, train additional providers and community agents, and make their services known.
In Phase III, Pathfinder aims to build off its success of the earlier phases – including increased knowledge and acceptance of FP and birth spacing concepts and increased availability of quality FP/RH services. However, it recognizes the key gaps it needs to overcome, including cultural and religious norms and lack of adequate number and quality of FP/RH services in the communities in which it works. Findings from the survey have influenced the design of the following activities that are currently being implemented in Phase III:

- **Development of appropriate IEC and BCC materials**: Pathfinder centrally produces culturally sensitive and acceptable IEC materials for distribution by implementing partners. Such IEC materials include posters, handbills, pamphlets, T-shirts, and fez caps. The messages took into consideration the findings of the community survey. Also, Pathfinder and other Packard grantees, including the *ku saurara* project of JHU, have collaborated to harmonize the IEC messages and are in the midst of producing additional materials. Previously used messages have also been translated into Hausa.

- **Training religious leaders to increase knowledge and acceptance of services**: Considering the role religious leaders play in the lives of community members, an additional 65 religious leaders were trained in Kano in March 2007. The major objective was to train them on how to include accurate information on modern concepts, especially RH issues, in their sermons. The training also taught the religious leaders how to access accurate information on the internet and other relevant sources of literature.

- **Training of CBDs (including training on HIV/AIDS) and recruiting new CBDs**: Pathfinder and its implementing partners are currently training new CBDs on RH/FP service delivery. This includes information and commodity distribution, referrals, and counseling. In addition, a new crop of unconventional CBDs such as beauticians (*Mai lalle*), hair stylists (*Mai kitso*), and barbers (*wanzamai*) are being trained, due to the very close contact they have with families and especially with young people.

- **Additional training of service providers**: Pathfinder has trained service providers on supervisory skills, service provision, and VCT.

- **Well baby clinics**: Well-baby clinics have been integrated with RH/FP services. The clinics aim to reduce morbidity and mortality among children under the age of five years through growth monitoring, nutrition counseling, immunization, oral rehydration, respiratory infection prevention, and malaria counseling. By integrating RH/FP services into these clinics, it will be easier for mothers to obtain these services at one stop.

- **Expanding to public services and supplying facilities with equipment and commodities**: Pathfinder has expanded to new public facilities in all the project states and FCT. As was applied in the previous two phases, Pathfinder further improves the capacity of health facilities by providing them with commodities and equipment.

- **Establishment of VCT centers**: Two service providers from all new facilities will be trained on VCT and, where possible, VCT centers will be established in the new facilities. Where VCT centers are not yet established, links will be made with existing VCT centers and other HIV/AIDS resources.

It is Pathfinder’s hope that the changes outlined above will lead to reduced traditional and religious barriers, increased knowledge and understanding about the need for RH/FP services, improved quality of health services through training of community workers and health providers, and increased access to child health and RH services in its project communities.
Appendix A: Data Collection and Coordination Information, by State

<table>
<thead>
<tr>
<th>State</th>
<th>State Coordinator</th>
<th>PI Staff</th>
<th>Locations</th>
<th>PI Grantees in State</th>
<th>No. of selected project Facilities</th>
<th>Survey location</th>
<th>Coordinating grantee (bold) and type of targeted FGD for implementation</th>
</tr>
</thead>
</table>
| Kano    | Dr Salisu         | Dr Sada  | Metropolitan Kura axis     | MWAN WAP SWODEN PPFN GMD YOSPIS YEDA | 30       | Metropolis                          | YOSPIS: PHE  
PPFN: MM  
SWODEN: TBA, PMV  
WAP: WRA, MRA  
YEDA: Youth male & female          |
| Katsina | Dr Ahmed Gana     | Dr Sada  | Katsina Town Funtua Jibia  | PPFN ARFYD KNH       | 8        | Katsina                             | PPFN: PMV, TBA  
ARFYD: MRA, WRA, Youth male & female                     |
| Kaduna  | Dr Sambo          | Esco     | Kaduna Zaria Kafanchan Kachia | WRHC PPFN FOMWAN TPA PARE | 16       | Kaduna                              | PPFN: PMV, MM  
WARHC: MRA  
PARE: TBA/CHEWS  
FOMWAN: WRA  
TPA: Youth male & female, PHE                   |
| Sokoto  | Mr Israel Sule    | Fatima   | Metropolitan               | PMM PPFN             | 7        | Metropolitan                        | PPFN: PMV, TBA MM, MRA,  
PMM: WRA, TBA, youth male & female                 |
| Niger   | Mr Benson Olubodun| Dije     | Minna Suleja/Diko Bida     | PPFN AGPMPN CCRHS DCDA | 13       | Minna                               | CCRHS: Youth male & female  
PPFN: TBA                     |
| Borno   | Dr Lagerma        | Lawan    | Metropolitan Bama Baga     | COCIN AYAMSU SUNNI PPFN | 15       | Metropolitan                        | COCIN: MRA, WRA, youth male & female  
SUNNI: TBA  
PPFN: PHE, PMV, MM               |
| FCT     | Ms Bosede Oguntuberu| Dr Mai  | Nyanya Mararaba Metropolitan Kubwa Gwagwa | Star GMD            | 20       | Metropolitan                        | STAR: MM, TBA, PMV, WRA, MRA, Youth male & female |

*National Coordinator  
Toyin Akpan  
toyinakpan@yahoo.com

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## Appendix B: Focus Group Discussion and Interview Data

### Proposed and Actual Respondents by Type

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Type of Evaluation Method</th>
<th>Survey Sample</th>
<th>Proposed Respondents</th>
<th>Actual Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health providers: trained providers and managers</td>
<td>IDIs</td>
<td>2 managers 2 trained personnel in a supported Service Delivery Point (SDP) per state</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Gatekeepers/Opinion leaders</td>
<td>KII per state</td>
<td>10 KIIIs per state</td>
<td>70</td>
<td>44</td>
</tr>
<tr>
<td>PHC coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional rulers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious leaders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCH coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opinion leaders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TBAs</td>
<td>FGD</td>
<td>7 FGD (8 agents/FGD)</td>
<td>56</td>
<td>61</td>
</tr>
<tr>
<td>MMs</td>
<td>FGD</td>
<td>7 FGD (8 agents/FGD)</td>
<td>56</td>
<td>57</td>
</tr>
<tr>
<td>PHEs</td>
<td>FGD</td>
<td>7 FGD (8 agents/FGD)</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>PMVs/MBDs</td>
<td>FGD</td>
<td>7 FGD (8 agents/FGD)</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>WRA</td>
<td>FGD (10 women/FGD)</td>
<td>7 FGD (10 women/FGD)</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>MRA</td>
<td>FGD (10 men/FGD)</td>
<td>7 FGD (10 men/FGD)</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td>Youth (Male)</td>
<td>FGD (8 youth/FGD)</td>
<td>7 FGD (8 youth/FGD)</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>Youth (Female)</td>
<td>FGD (8 youth/FGD)</td>
<td>7 FGD (8 youth/FGD)</td>
<td>56</td>
<td>54</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>574</strong></td>
<td><strong>511</strong></td>
</tr>
</tbody>
</table>

### Actual Breakdown of 511 Respondents for FGDs and interviews by State

<table>
<thead>
<tr>
<th>Targets</th>
<th>Sokoto</th>
<th>FCT</th>
<th>Niger</th>
<th>Kano</th>
<th>Borno</th>
<th>Kaduna</th>
<th>Katsina</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMV/MBD</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>+</td>
</tr>
<tr>
<td>MRA</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>MM</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>10+++</td>
</tr>
<tr>
<td>WRA</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Youth female</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Youth male</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>+++</td>
</tr>
<tr>
<td>TBA</td>
<td>16</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>PHE</td>
<td>+++</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Health providers</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Gatekeepers/Opinion leaders</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
<td><strong>76</strong></td>
<td><strong>75</strong></td>
<td><strong>76</strong></td>
<td><strong>77</strong></td>
<td><strong>73</strong></td>
<td><strong>58</strong></td>
</tr>
</tbody>
</table>

* A focus group discussion was conducted, but the exact number of respondents not recorded.
*++ This focus group discussion included 4 females.
+++ Not conducted.